Baylor Scott & White
ANNETTE C. AND HAROLD C. SIMMONS TRANSPLANT INSTITUTE
BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS
BAYLOR SCOTT & WHITE ALL SAINTS MEDICAL CENTER – FORT WORTH

KIDNEY TRANSPLANT APPLICATION

I would like to be considered for: □ Kidney □ Kidney/Pancreas □ Pancreas Only

I would like to have my evaluation testing in: □ Dallas □ Longview □ Fort Worth □ Lubbock □ Amarillo

PATIENT INFORMATION	Printed Name:		
Address: Apt #:	City: State: Zip:		
Social Security #:	Date of Birth:	Sex: □ Male □ Female	
Race: □ White □ Black □ Asian □ American Indian/Eskimo/ALEU □ Hawaiian Native/Pacific Islander □ Other			
Ethnicity: □ Hispanic Origin □ Not of Hispanic Origin			
Phone #: Cell #: E-mail:			
U.S. Citizen: □ Yes □ No	Language Preference:	Do you speak English: □ Yes □ No	
Emergency Contact:	Phone #:		

MEDICARE/MEDICAID INFORMATION (Please include a copy of all insurance cards)		
Medicare ID#:	Medicaid ID#:	Texas Kidney Health Plan #:

INSURANCE INFORMATION		
Primary Policy Holder's Name:	Date of Birth:	Social Security #:
Insurance Company:	Customer Service #:	
Policy / ID #:	Group #:	
Insurance premiums are paid by: ☐ Self ☐ Employer ☐ Dialysis Center ☐ American Kidney Fund ☐ Other_____		

ADDITIONAL INFORMATION	Referring Physician:		
Address:	City: State: Zip:		
Phone #:	Fax #:		
Name of Dialysis Center:	Phone #: City:		
Dialysis Center Social Worker:			
Type of Dialysis: □ Not yet on dialysis □ Peritoneal □ Hemodialysis □ Home Hemodialysis		Height: Weight:	
Dialysis Days: □ M/W/F □ T/Th/Sat	Date of first dialysis:		
Previous Transplant: □ Yes □ No	If Yes, Transplant Center: City:	Date:	

PATIENT REQUEST TO BEGIN EVALUATION AND FINANCIAL CLEARANCE PROCESS

I request that Baylor Scott & White All Saints Medical Center – Fort Worth (FW) and Baylor University Medical Center, part of Baylor Scott & White (BUMC) begin the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start this process. I authorize my physicians to release my medical records to FW and BUMC. I authorize FW and BUMC to release any medical information pertaining to my diagnosis and/or treatment, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment, or any other such related information to: 1) Representatives of local, state or federal agencies in accordance with law; 2) Medicare; 3) Medicaid; 4) my insurance company or its designated representatives; 5) any person(s) or entities financially responsible for my care or treatment; 6) employees and/or representatives of FW and BUMC for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against FW and BUMC and/or any member of the medical and house staff at FW and BUMC; and/or 7) individuals or entities for quality improvement, educational, medical research, accreditations or other purposes customarily utilized by hospitals and medical staffs in carrying out their functions. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for any medical expenses incurred at FW and BUMC. I further authorize release of this information to healthcare providers associated with my care outside FW and BUMC to facilitate further healthcare.

Patient Signature: Date:

REQUIRED DOCUMENTS (Please provide a copy of the following required documents)

- □ Copy of Government Issued I.D. such as Drivers License or Passport
- □ Copy of Insurance Card(s) – front and back
- □ Recent History and Physical from Nephrologist (within past year)
- □ Most Recent Height and Weight from Nephrologist or Dialysis Center

If on Dialysis:
- □ Recent History of Compliance
- □ TB Test (within past year)
- □ Copy of HCFA 2728 Form

If Not on Dialysis: □ eGFR or 24 Hour Creatinine Clearance

Addresses for Baylor Scott & White Annette C. and Harold C. Simmons Transplant Institute applications are:

For Dallas and Longview:
Baylor University Medical Center
Abdominal Transplant Program
Attention: Pre-Transplant Department
3410 Worth Street, Suite 950, Dallas, TX 75246
PH: 214.820.2050 • Fax: 214.820.6213

For Fort Worth, Lubbock and Amarillo:
Baylor Scott & White All Saints Medical Center - Fort Worth
Attention: Pre-Transplant Department
1400 8th Avenue, Fort Worth, TX 76104
Ph: 817.922.4650 • Fax: 817.922.2310